Kenya's population: 5 key findings in the past 20 years of research

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Like many countries on the African continent, Kenya's population is growing—fast. The country's population was 8.1 million in 1963; today it stands at about 55 million people. More people have moved into urban

areas too. In 1960 about 7% of the population lived in urban areas; by 2021 it stood at 28%.

Some key changes within Kenya's society have taken place alongside, and because of, this fast growth.

I'm the executive director of the African Population and Health Research Center (APHRC), an organization which has been documenting population changes and dynamics in Kenya, and other countries, for 20 years. This work has helped to influence public policy and response.

Some of the key challenges identified in Kenya have been:

- a large number of urban residents, especially those in informal settlements, without social services such as public health facilities;
- shortage of public schools (government funded);
- widespread non-communicable diseases and their risk factors in urban informal settlements;
- a high number of unsafe abortions driven by high levels of mistimed and unwanted pregnancies; and
- uneven progress in sustainable development goals (SDGs) targets related to mothers, children and adolescents.

These findings are key to driving effective strategies.

Urban residents without access to services

Kenya's development partners have tended to assume that urban areas and residents were well-served by social services, and didn't need special attention from government and civil society organizations. As a result, in the 1980s and 1990s, poverty alleviation programs focused on rural areas.

However, in 2002 we produced evidence that showed huge differences in health, education and other social outcomes among residents of urban informal settlements when compared to other urban residents. For some outcomes, residents of urban informal settlements were doing as badly as rural residents, if not worse. For instance, we found that children living in slums were sicker than those living elsewhere in Kenya. They were also less likely to get treatment when they were sick.

Our work highlighted the important point that simply presenting national statistics for rural and urban areas, without breaking them down further by socioeconomic status, was highly misleading. If countries were to make progress towards various development targets, urban informal settlements needed special attention.

Understanding this led to the design of projects and programs by governments and other agencies that targeted disadvantaged urban areas. Over time, great progress has been made and the health and other social indicators in these areas have improved.

Shortage of public schools

Free primary education was implemented in Kenya in 2003. Its main objective was to make primary education accessible to all. Research done at APHRC, however, showed that the enrollment of children in

public schools went up for a couple of years and then rapidly declined.

In 2012, 63% of primary school students in Nairobi urban informal settlements were attending non-government schools, a percentage as high as it had been before the policy. This happened because there were not enough public schools to meet the demand. Parents realized that their children were not receiving the right amount of attention in overcrowded classrooms. Instead, they took their children back to the informal private schools they had been attending before the policy was rolled out.

Once our evidence was shared with the ministry of education, the Education Taskforce of 2012 adopted recommendations to include all learners, including those in non-formal schools, who met set criteria to benefit from capitation grants. This was to ensure that learners in informal settlements benefited from the government program.

Widespread diseases in informal settlements

A key health-related finding was that non-communicable diseases, and their risk factors, showed a high prevalence in the urban informal settlements of Nairobi.

There was a huge burden of undiagnosed, untreated and uncontrolled disease. For instance, about 80% of adults diagnosed with diabetes and high blood pressure were previously undiagnosed. Among those who had been previously diagnosed, the majority had not received treatment in the past 12 months. Only a fraction had received treatment in the past two weeks. As a result, for every 100 people diagnosed with either condition, only one had it under control.

These findings are vital to understanding existing or potential gaps in a healthcare system. They shaped the APHRC's subsequent research programs on developing models to improve care for chronic conditions

in these settings. Some of these have been adopted by Nairobi County and other players.

Huge number of unsafe abortions in Kenya

In 2013, APHRC published the report of the first ever incidence and magnitude study on unsafe abortion. The study estimated that over 464,000 abortions had been conducted in Kenya, and an estimated 120,000 women sought care in health facilities for complications. According to the World Health Organization, 4.7% to 13.2% of maternal deaths annually can be attributed to unsafe abortion.

An estimated half (49%) of all pregnancies were unintended and four in ten of these ended in an abortion, highlighting the need for increased access to contraception.

Uneven progress in supporting mothers and children

APHRC has been supporting the analysis of routine health information and survey data to track African countries' progress towards meeting the SDG targets related to mothers, children and adolescents. These include the reduction in maternal mortality and the end of preventable deaths of newborns and children.

The analysis—conducted for at least 18 countries—shows a general trend of improvement in various outcomes at the country level, but also huge differences between regions for some indicators. For instance in Kenya, childhood mortality has declined from 99 per 1,000 live births in 2000 to 31 in 2020. Estimates from 2014 show significant regional differences, with the worst performing sub-region (coast) having more than double the rate of child deaths compared with the best performing one (central)—87.4 against 42.1.

The progress seen at national level can be explained by improvements in health outcomes in some regions, but not all. This analysis is important to provide evidence about how government and development partners can target resources towards disadvantaged regions if Kenya is to meet the SDG targets.

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